DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 04-03

2. STATE: Alaska

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
January 1, 2004

5. TYPE OF PLAN MATERIAL *(Check One)*:

NEW STATE PLAN | AMENDMENT TO BE CONSIDERED AS NEW PLAN | AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 447.250-252 and 447.256-.299

7. FEDERAL BUDGET IMPACT:
a. FFY 04 $ (69,000)
b. FFY 05 $ (138,000)
Please see Box 10, below

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 4.19-A, Pages 1-6, 9-10, 21-22
Attachment 4.19-D, Pages 1-11 and 13

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-A , Pages 1-6, 9-10, 21-22
Attachment 4.19-D, Pages, 1-11 and 13

10. SUBJECT OF AMENDMENT

Inpatient Payment Rate Update

11. GOVERNOR'S REVIEW *(Check One)*:
GOVERNOR'S OFFICE REPORTED NO COMMENT
COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
OTHER, AS SPECIFIED: Governor does not wish to comment.

12. SIGNATURE OF STATE AGENCY OFFICIAL:

16. RETURN TO:
Alaska Department of Health and Social Services
Office of the Commissioner
P.O. Box 110601
Juneau, Alaska 99811-0601

13. TYPED NAME:
Bob Labbe

14. TITLE:
Deputy Commissioner/Medicaid Director

15. DATE SUBMITTED:
March 31, 2004

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: APR - 2 2004

18. DATE APPROVED:

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: JAN - 1 2004

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:

22. TITLE:

FORM HCFA-179 (07-92)

STATE PLAN FOR MEDICAID PROVIDER REIMBURSEMENT

INPATIENT HOSPITAL

Inpatient hospital services provided by acute care, specialty, and psychiatric hospitals are paid for Medicaid recipients by means of rates determined in accordance with the following principles, methods and standards which comply with [42 CFR 447.250 THROUGH 477.299] 1902(a)(13)(A), 1902(a)(30), and 1923 of the Social Security Act and Federal regulations at 42 CFR 447.250 through .252, .256, .257, .272, .280, and .296 through .299.

I Introduction:

Rate setting principles and methods are contained in Alaska Statutes 47.07.070 - 47.07.900 and administrative regulations in Alaska Administrative Code 7 AAC 43.

For purposes of this section the following definitions apply:

1. Acute Care Hospital – means a facility that provides inpatient hospitalization for medical and surgical care of acute illness or injury and perinatal care.

2. Specialty Hospital – means a rehabilitation hospital that is operated primarily for the purpose of inpatient care assisting in the restoration of persons with physical handicaps.

3. Psychiatric Hospital – means a facility that primarily provides inpatient psychiatric services for the diagnosis and treatment of mental illness; "psychiatric hospital" does not include a residential treatment center.

Data sources used by the Department of Health and Social Services (the Department) are the following:

1. When rebasing occurs, the Medicare Cost Report for the facility's fiscal year ending 12 months before the beginning of the year that is rebased (base year).

2. Budgeted capital costs, submitted by the facility and reviewed and adjusted by the Department as appropriate in accordance with Section II, for the rate year on capital projects or acquisitions which are placed in service after the base year and before the end of the rate year and for which an approved Certificate of Need has been obtained.

3. Year end reports which contain historical financial and statistical information submitted by facility's for past rate setting years.

4. Utilization and payment history report (commonly known as the MR-0-14) provided by the Division of Health Care Services.

II Allowable Costs:

Allowable costs are documented costs that are ordinary and necessary in the delivery of a cost effective service. Allowable costs are those which directly relate to Title XIX program recipients. Costs would include those necessary to conform with the state and federal laws, regulations, and quality and safety standards.

Most of the elements of Medicaid allowable costs are defined in Medicare and reported, subject to audit, on the Medicare Cost Report. The following items are possible adjustments from financial statement classifications to Medicaid classifications, and may be reflected either within the Medicare Cost Report or elsewhere in the Medicaid cost finding process.

* return on investment is not an allowable cost for any facility.

* advertising cost is allowable only to the extent that the advertising is directly related to patient care. The reasonable cost of only the following types of advertising and marketing is allowable:
  - announcing the opening of or change of name of a facility.
  - recruiting for personnel.
  - advertising for the procurement or sale of items.
  - obtaining bids for construction or renovation.
  - advertising for a bond issue.
  - informational listing of the provider in a telephone directory.
  - listing a facility's hours of operation.
  - advertising specifically required as a part of a facility's accreditation process.

* physician compensation costs and related charges associated with providing care to patients are not allowable for purposes of calculating a prospective payment rate.

* medical services which a facility or unit of a facility is not licensed to provide are not included as an allowable cost.

* costs not authorized by a certificate of need when a certificate of need is required are not included as an allowable cost.

* Management fees or home office costs which are not reasonably attributable to the management of the facility. Home office costs may not exceed those reported in the most recently Medicare audited Home Office Cost Report.

Allowable patient related costs include wages, salaries, and employee benefits, purchased services; supplies; utilities, depreciation, rentals, leases; taxes, excluding local, state and federal income taxes; and interest expense. A facility must reduce operating costs by the cost of all activities not directly related to health care. Other specific non allowed costs are bad debts, charity, contractual adjustments and discounts taken by payers.

If a certificate of need is required on assets purchased after July 1, 1990, the amount of capital costs included in the rate calculation will be limited to the amounts described within the certificate of need application and other information the facility provided as a basis for approval of the certificate of need. In determining whether capital costs exceed those amounts approved under a certificate of need, the department will consider:

(1) the terms of issuance describing the nature and extent of the activities authorized by the certificate; and

(2) the facts and assertions presented by the facility within the application and certificate of need review record, including purchase or contract prices, the rate of interest identified or assumed for any borrowed capital, lease costs, donations, developmental costs, staffing and administration costs, and other information the facility provided as a basis for approval of the certificate of need.

III Inflation Adjustments:

Allowable base year costs are adjusted for inflation. The department will utilize the most recent quarterly publication of Global Insight's "Health Care Cost Review" available 60 days before the beginning of a facility's fiscal year. For the inflation adjustment relating to allowable non-capital costs, the department will utilize the Global Insight Hospital Market Basket. Allowable capital and allowable home office capital will be adjusted using the Global Insight Health Care Costs, Building Cost Index, CMS New 1997-based PPS Hospital Capital IPI.

IV Determination of Prospective Payment Rates:

The prospective payment rate for inpatient hospital services rendered to Medicaid recipients is a per-day rate reflecting costs related to patient care and attributable to the Medicaid program. Prospective payment rates will be determined under one of three methodologies – Basic, Optional, and New Facilities.

a. Basic Prospective Payment Rate Methodology

The prospective payment rate consists of four components – costs excluding capital for routine cost centers, capital costs for routine cost centers, capital costs for ancillary cost centers, and costs excluding capital for ancillary cost centers. The prospective payment rates will be annual rates based on the facility's fiscal year. Except for facilities electing to be reimbursed under the optional payment rate methodology detailed in Subsection IVb, re-basing will occur for all facilities no less than every four years.

The prospective per-day rates for inpatient acute care, specialty, and psychiatric hospitals are computed as follows:

1. Total allowable base year costs excluding capital costs for each routine cost center are divided by the total inpatient days in that cost center and the resulting per-day cost is multiplied by allowable paid Medicaid days in that cost center to arrive at Medicaid allowable base year routine costs for that cost center. The sum of the Medicaid allowable base year costs for all routine cost centers are divided by the sum of the allowable paid Medicaid inpatient days for all routine cost centers resulting in the facility's base year Medicaid specific non-capital routine cost per-day.

2. Total allowable base year capital costs for each routine cost center are divided by the total inpatient days in that cost center and the resulting per-day cost is multiplied by allowable paid Medicaid days in that cost center to arrive at Medicaid allowable base year routine capital costs for that cost center. The sum of the Medicaid

allowable base year capital costs for all routine cost centers are divided by the sum of the allowable paid Medicaid inpatient days for all routine cost centers resulting in the facility's base year Medicaid specific capital routine cost per-day.

3. The percentage of base year capital costs in each ancillary cost center is applied to the Medicaid ancillary costs for the cost center calculated by first dividing allowable ancillary costs by total inpatient days and applying the resulting per-day costs to paid Medicaid inpatient days. The sum of the Medicaid allowable capital costs for all ancillary cost centers is divided by the sum of the allowable paid Medicaid inpatient days for all ancillary cost centers resulting in the facility's base year Medicaid specific capital ancillary cost per day.

4. The sum of the Medicaid allowable capital costs for all ancillary cost centers determined in 3. is removed from the total base year Medicaid specific ancillary costs determined by dividing total base year ancillary costs by total inpatient days and applying the resulting amount to total paid Medicaid inpatient days. The resulting base year allowable ancillary cost is then divided by paid Medicaid inpatient days to arrive at the facility's base year Medicaid specific non-capital ancillary cost per-day.

Each base year component rate is then adjusted for inflation in accordance with Section III and summed to arrive at the facility's prospective payment rate.

The capital components of the prospective payment rate will be adjusted to reflect appropriate capital costs for the prospective year based on certificate of need documentation, assets retired in conjunction with the certificate of need, and Medicare cost reporting requirements.

For purposes of determining prospective payment rates, nursery days constitute inpatient days and swing-bed days do not constitute inpatient days. Costs and charges associated with swing-bed services, determined by applying the swing-bed rate in the base year to the number of swing-bed days, are removed prior to calculating the prospective payment rate. For the routine cost centers, the Medicaid inpatient days are the covered days from payment history reports generated by the Division of Health Care Services (commonly known as the MR-0-14). For the ancillary cost centers, Medicaid inpatient days will be those days reported in either the facility reported Medicaid audited days or covered days from the payment history reports.

Prospective payment rates for facilities that are calculated and paid on a per-day basis as discussed in this Section will be no greater than the per-day rates proposed in the certificate of need application and other information provided as a basis for approval of the certificate of need for the first year during which the following are available for use and for two years immediately following the first year:

(1) opening of a new or modified health care facility;
(2) alteration of bed capacity; or
(3) the implementation date of a change in offered categories of health service or bed capacity.

If a facility is granted a certificate of need for additional beds, the additional capital payment add-on to the per-day rate will include the base year's inpatient days plus additional days associated with the additional beds. The additional days are calculated as the base year's occupancy percentage multiplied by 80 percent and then multiplied by the additional beds approved in the certificate of need. The resulting figure is further multiplied by 365.

Except for critical access hospitals, costs are the lower of costs or charges in the aggregate to the general public.

b. Optional Prospective Payment Rate Methodology and Criteria for Small Facilities

A facility that had 4,000 or fewer total inpatient hospital days as an acute care, specialty or psychiatric hospital, or as a combined hospital-nursing facility during the facility's fiscal year that ended 12 months before the beginning of its prospective payment rate year during calendar year 2001 may elect to be reimbursed for inpatient hospital services under provisions of this Subsection. If a facility that meets this criteria does not elect to participate during its first fiscal year after December 31, 2000, the facility may not elect to participate under the provisions of this Subsection until after a re-basing occurs under the provisions of Subsection IVa.

If a facility that elected to be reimbursed under the prior Optional Payment Rate Methodology for Small Hospitals for its payment years beginning in calendar year 1998 until the last day of its fiscal year ending during the period of July 1, 2001 through June 30, 2002, does not elect to participate after its agreement expires or does not terminate the agreement for its first fiscal year beginning after December 31, 2000, the facility may not elect to participate under the provisions of this Subsection until after a re-basing occurs under the provisions of Subsection IVa.

If a new facility is licensed, the rates will be calculated as follows:

For acute care and specialty hospitals, the inpatient per-day rate will be established at the statewide weighted average of inpatient per-day rates and of acute care and specialty hospitals in accordance with this section for the most recent 12 months of permanent rates; patient rates are the statewide weighted average using the base year's patient days.

For inpatient psychiatric hospitals, the inpatient prospective payment rate will be established at the statewide weighted average of inpatient per-day rates of psychiatric hospitals for the most recent 12 months of permanent rates; rates are the statewide weighted average using the base year's patient days.

Prospective payment rates for new facilities will be established under the provisions of Section IV after two full years of cost data is reported.

V (Reserved)

VI Sale of Facilities:

An appropriate allowance for depreciation, interest on capital indebtedness and (if applicable) return on equity capital for an asset of a facility which has undergone a change of ownership will be valued at the lesser of the allowance acquisition cost of the asset to the owner of record on or after July 18, 1984, or the acquisition cost of the asset to the new owner in accordance with Section 1861(v)(1)(O) of the Act. In addition, the recapture of depreciation expense on disposition of assets that accommodate gains under the Medicaid program will be limited by the provisions of Section 1861(v)(1)(O)(ii) of the Act. Payment for acquisition costs associated with buying and selling of the facility will be limited by the provisions of Section 1861(v)(1)(O)(iii) of the Act.Adjustment to Rates:

VII. Adjustment to Rates

All rates for facilities are set by the department. Facilities have the opportunity to provide additional information on significant changes that would impact the rates.

The department on its own motion or at the request of an applicant may reconsider its actions within 30 days. There is nothing to preclude a facility from petitioning the department at any time during its fiscal year for additional consideration.

Reconsiderations are warranted only in those cases where the proper application of the methods and standards described in Attachment 4.19-A is in question or is being challenged.

VIII Provider Appeals:

If a party feels aggrieved as a result of the department's rate setting decisions, the party may appeal and request reconsideration or an administrative hearing. Administrative hearings are conducted by Governor appointed Hearing Officers. An administrative appeal must be filed within 30 days of the mailing of the decision of the department.

The Hearing Officer would hear a case in accordance with administrative law in the State of Alaska. The Hearing Officer would prepare draft findings, conclusions and order for the commissioner of the department's review. The commissioner of the department would review the findings of the Hearing Officer and may accept, reject, or modify the

XII. Exceptional Relief to Rate Setting:

If the rate setting methodology results in a permanent rate which does not allow reasonable access to quality patient care provided by an efficiently and economically managed facility, the facility may apply to the deputy commissioner of the department for exceptional relief from the rate setting methodology. This provision applies to situations where a facility is forced to close or dramatically reduce quality of care to its residents due to the inadequacy of its payment rate. To apply for exceptional relief, the facility's application should include:

1. the amount by which the facility estimates that the rate should be increased to allow reasonable access to quality patient care provided by an efficiently managed facility;

2. the reasons why and the need for exceptional relief requested, including any resolution by the facility's governing body to support the reasons offered, and why such a rate increase cannot be obtained through the existing rate setting process;

3. the description of management actions taken by the facility to respond to the situation on which the exceptional relief request is based;

4. the audited financial statement for the facility for the most recently completed facility fiscal year and financial data, including a statement of income and expenses and a statement of assets, liabilities, and equities and a monthly facility cash flow analysis for the fiscal year for which the exception is requested;

5. a detailed description of recent efforts by the facility to offset the deficiency by securing revenue sharing, charity or foundation contributions, or local community support;

6. an analysis of community needs for the service on which the exception request is based;

7. a detailed analysis of the options of the facility if the exception is denied;

8. a plan for future action to respond to the problem; and

9. any other information requested by the deputy commissioner to evaluate the request.

The deputy commissioner may increase the rate, by all or part of the facility's request if the deputy commissioner finds by clear and convincing evidence that the rate established under section IV of Attachment 4.19-A does not allow for reasonable access to quality patient care provided by an efficiently and economically managed facility and that the granting of an

exception is in the public interest. In determining whether the exception is in the public interest, the deputy commissioner may consider at least:

1. the necessity of the rate increase to allow reasonable access to quality patient care provided by an efficiently and economically managed facility, including any findings of the governing body of the facility to support the need;

2. the assessment of continued need for this facility's services in the community;

3. whether the facility has taken effective steps to respond to the crisis and has adopted effective management strategies to alleviate or avoid the future need for exceptional relief;

4. the availability of other resources available to the facility to respond to the crisis;

5. whether the relief should have been obtained under the existing rate methodology;

6. other factors relevant to assess reasonable access to quality patient care provided by an efficiently and economically managed facility.

The deputy commissioner will impose conditions on the receipt of exceptional relief including, but not limited to the following:

1. the facility sharing the cost of the rate exception granted;

2. the facility taking effective steps in the future to alleviate the need for future requests for exceptional relief;

3. the facility providing documentation as specified of the continued need for the exception; or

4. a maximum amount of exceptional relief to be granted to the facility under this section.

Amounts granted as exceptional relief shall not be included as part of the base on which future prospective rates are determined. Exceptional relief shall be effective prospectively from the date of the exceptional relief decision and for a period of time not to extend beyond the facility's rate setting year. A facility may apply for and be granted exceptional relief in the following year. A party aggrieved by a decision of the deputy

expenses and a statement of assets, liabilities, and equities and a monthly facility cash flow analysis for the fiscal year for which the exception is requested;

5. a detailed description of recent efforts by the facility to offset the deficiency by securing revenue sharing, charity or foundation contributions, or local community support;

6. an analysis of community needs for the service on which the exception request is based;

7. a detailed analysis of the options of the facility if the exception is denied;

8. a plan for future action to respond to the problem; and

9. any other information requested by the deputy commissioner to evaluate the request.

The Deputy Commissioner may increase the rate, by all or part of the facility's request if the Deputy Commissioner finds by clear and convincing evidence that the rate established under Section IV. and Section VI. of Attachment 4.19-D does not allow for reasonable access to quality patient care provided by an efficiently and economically managed facility and that the granting of an exception is in the public interest. In determining whether the exception is in the public interest, the Deputy Commissioner may consider at least:

1. the necessity of the rate increase to allow reasonable access to quality patient care provided by an efficiently and economically managed facility, including any findings of the governing body of the facility to support the need;

2. the assessment of continued need for this facility's services in the community;

3. whether the facility has taken effective steps to respond to the crisis and has adopted effective management strategies to alleviate or avoid the future need for exceptional relief;

4. (Reserved)

5. the availability of other resources available to the facility to respond to the crisis;